NOE VALLEY PEDIATRICS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME(S): _____

NOE VALLEY PEDIATRICS' PRIVACY PLEDGE: The staff and health care providers of Noe Valley Pediatrics understand that information about your child and their health is personal and they are committed to protecting your child's health information. All staff must follow the rules in this notice.

YOUR RIGHTS:

- The right to ask to see, read or obtain a copy of your child's health record. (Copy charges may apply.)
- The right to ask to correct information that you believe is wrong in your child's health record.
- The right to ask that your child's health information not be shared with certain individuals.
- The right to ask that your child's health information not be used for certain purposes, e.g., research.
- The right to ask, in writing, that copies of your child's health record be sent to whomever you wish.
- The right to be informed about who has read your child's health record for reasons other than treatment, payment and program improvement purposes.
- The right to specify where and how the staff of Noe Valley Pediatrics may contact you.
- The right to receive a paper copy of the full Noe Valley Pediatrcs Notice of Privacy Practices.

USE OF INFORMATION:

Noe Valley Pediatrics may use and disclose your information *within the practice* to improve the quality of care that your child receives. This disclosure may include information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases and developmental disabilities. Health information about your child will NOT be shared beyond the above mentioned without your written permission. If you have concerns about how your child's health information might be shared, please speak with your child's physician or call the Office Manager at (415) 641-1019.

If you believe that your privacy rights have NOT been maintained while receiving services, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 332, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

By signing this form, I am consenting to allow Noe Valley Pediatrics to use and disclose my protected health information as described above to carry out treatment, payment and health care operations. I further acknowledge my right to receive the Noe Valley Pediatrics' Notice of Privacy Practices.

SIGNATURE:

Signature of Patient/Parent/Guardian or Authorized Representative	Date
Printed Name of Authorized Representative	Relationship to patient